



Physical Activity Readiness Questionnaire (PAR-Q)

Last Name _____	Birth Date _____
First Name _____	
Address _____	<input type="checkbox"/> Married <input type="checkbox"/> Single
City _____ State _____ Zip Code _____	
Home Phone _____ Mobile _____	Height _____ Weight _____
E-mail _____	<input type="checkbox"/> Male <input type="checkbox"/> Female

1. ☐ Yes ☐ No Has your doctor ever said you have a heart condition and recommended only medically supervised physical activity?
2. ☐ Yes ☐ No Has your physician ever told you that you have a joint or bone problem that has been or could be made worse by exercise?
3. ☐ Yes ☐ No Are you over age 65?
4. ☐ Yes ☐ No Do you have chest pain brought on by physical activity?
5. ☐ Yes ☐ No Are you aware through your own experiences or a doctor's advice of any other reason against your exercising without medical supervision?
6. ☐ Yes ☐ No Has a doctor ever recommend medication for your blood pressure or a heart condition?
7. ☐ Yes ☐ No Do you tend to lose consciousness or fall over as a result of dizziness?

If you answered yes to one or more of the questions above please answer and initial the following questions.

8. ☐ Yes ☐ No Have you consulted your physician regarding increasing your physical activity and/or performing a fitness assessment? _____ Initial
9. ☐ Yes ☐ No If you answered no to question 8 will you contact your physician prior to increasing your physical activity and/or performing a fitness assessment? _____ Initial

Medical History: Please check all conditions that apply

- | | |
|---|--|
| 1. <input type="checkbox"/> Yes <input type="checkbox"/> No Heart Disease or Stroke | 22. <input type="checkbox"/> Yes <input type="checkbox"/> No Psychological problems |
| 2. <input type="checkbox"/> Yes <input type="checkbox"/> No High Blood Pressure | 23. <input type="checkbox"/> Yes <input type="checkbox"/> No Anemia |
| 3. <input type="checkbox"/> Yes <input type="checkbox"/> No High Triglyceride | 24. <input type="checkbox"/> Yes <input type="checkbox"/> No Compulsive overeating disorder |
| 4. <input type="checkbox"/> Yes <input type="checkbox"/> No Cancer | 25. <input type="checkbox"/> Yes <input type="checkbox"/> No Other medical condition (s) that may have an impact on your participation in the Shape Club Fitness and Lifestyle Coaching (if checked please explain). |
| 5. <input type="checkbox"/> Yes <input type="checkbox"/> No Lung/Pulmonary Disease | 26. <input type="checkbox"/> Yes <input type="checkbox"/> No Pregnant/lactating or trying to conceive |
| 6. <input type="checkbox"/> Yes <input type="checkbox"/> No Kidney Disease | 27. <input type="checkbox"/> Yes <input type="checkbox"/> No Currently being monitored or have been advised to be monitored by a physician |
| 7. <input type="checkbox"/> Yes <input type="checkbox"/> No Osteoporosis | 28. <input type="checkbox"/> Yes <input type="checkbox"/> No Recommended high level care |
| 8. <input type="checkbox"/> Yes <input type="checkbox"/> No Ulcer | 29. <input type="checkbox"/> Yes <input type="checkbox"/> No Special diet |
| 9. <input type="checkbox"/> Yes <input type="checkbox"/> No Gastrointestinal Disease | |
| 10. <input type="checkbox"/> Yes <input type="checkbox"/> No Depression | |
| 11. <input type="checkbox"/> Yes <input type="checkbox"/> No Diabetes Mellitus (DM) | |
| 12. <input type="checkbox"/> Yes <input type="checkbox"/> No Obesity | |
| 13. <input type="checkbox"/> Yes <input type="checkbox"/> No Arthritis | |
| 14. <input type="checkbox"/> Yes <input type="checkbox"/> No Food Allergies | |
| 15. <input type="checkbox"/> Yes <input type="checkbox"/> No Bulimia | |
| 16. <input type="checkbox"/> Yes <input type="checkbox"/> No Anemia | |
| 17. <input type="checkbox"/> Yes <input type="checkbox"/> No Neuromuscular Disease | |
| 18. <input type="checkbox"/> Yes <input type="checkbox"/> No Diarrhea | |
| 19. <input type="checkbox"/> Yes <input type="checkbox"/> No Arteriosclerosis | |
| 20. <input type="checkbox"/> Yes <input type="checkbox"/> No Gallbladder Disease | |
| 21. <input type="checkbox"/> Yes <input type="checkbox"/> No Low back pain within last 6 months | |

Explanation: _____
